Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Melanie Cole, a prisoner at HMP Holloway on 10 March 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The woman died of breast cancer, which had spread to other organs, in March 2015, while a prisoner at HMP Holloway. She was 53 years old. I offer my condolences to her family and friends.

The woman had been diagnosed and treated for breast cancer in 2006 and continued to have regular consultant reviews. For most of the time she was at Holloway, I consider she received a good standard of care. Towards the end of summer 2014, she began to report symptoms, which, in late January 2015, led to her admission to hospital and a terminal diagnosis, as her cancer had spread. I agree with the clinical reviewer that her history of back pain, clear scans and other complex issues initially clouded the clinical picture. However, towards the end of her life she had symptoms, which should have been explored further. Prison doctors had requested a scan but this took some time for the hospital to arrange. Healthcare staff had chased the appointment but the clinical reviewer considers there should have been an urgent referral. While it does not appear that earlier diagnosis would have prolonged her life, it would have allowed her more timely access to palliative treatment.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2015**

Contents

Summary 1

The Investigation Process 2

Background Information 3

Findings 4

Action plan 9

Summary

Events

1. The woman had been at HMP Holloway since January 2011. In 2006, she had had a mastectomy for breast cancer and often saw a consultant for check ups. In August 2012, she had a bone scan to check whether the cancer had spread. The scan was normal.

2. The woman had longstanding back pain and, from July 2014, began to complain of further back pain. Later, she said had pains in her hip and shoulder. Doctors prescribed pain relief. An X-ray showed degenerative changes to her spine but nothing else abnormal. The radiologist noted that a bone scan would be needed if there were concerns about metastatic bone disease. No scan was done. In August, she attended a breast clinic for a check up and the consultant did not note any abnormalities. She did not mention any back or hip pain.

3. The woman continued to complain of shoulder pain and, from November, reported abdominal pain. A doctor referred her for a scan. On 28 January 2015, scans showed multiple lesions on her spine and liver. The hospital admitted her and carried out further tests, which showed that cancer had spread to her liver. On 6 February, doctors told her that no active treatment was possible and she had only about three weeks to live.

4. The woman remained in hospital and on 12 February, transferred to a hospice for end of life care. She died at the hospice in March. Her family were with her at the time.

Findings

5. The clinical reviewer noted that the woman had complex medical problems, which would have been difficult to manage in any environment. For most of her time at the prison, she received a good standard of care but there was a delay in diagnosing that cancer had spread to her liver, which could have been avoided by earlier referral to hospital. Part of the reason for the delayed referral appeared to be a lack of communication between different healthcare staff about her symptoms. The clinical reviewer noted that it is unlikely that earlier diagnosis would have prolonged her life, but it would have allowed her more timely access to palliative treatment.

Recommendations

- The Head of Healthcare should ensure that healthcare staff discuss complex cases as part of routine case management meetings, that all aspects of symptoms and treatment are considered and that they refer patients with symptoms indicative of cancer urgently to specialists, in line with National Institute for Health and Clinical Excellence (NICE) guidelines.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Holloway informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

7. The investigator obtained copies of relevant extracts from the woman's prison and medical records.

8. NHS England commissioned a clinical reviewer to review the woman's clinical care at the prison.

9. We informed HM Coroner for the City of London of the investigation who gave the cause of death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the woman's partner to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He was concerned that doctors at the prison had not properly investigated the cause of her symptoms.

11. The woman's family received a copy of the initial report. They did not make any comments. The prison also considered our initial report and submitted an action plan addressing our recommendations which is at the end of this report.

12. The investigation has assessed the main issues involved in the woman's care, including her diagnosis and treatment, whether appropriate palliative care was provided, her location, security arrangements for hospital escorts, liaison with her family, and whether compassionate release was considered.

Background Information

HMP Holloway

13. HMP Holloway is a prison for women in north London which serves courts across the south east of England. It holds approximately 500 women in single and double cells and multi-occupancy dormitories. Central & North West London NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Holloway was in June 2013. Inspectors commented that Holloway is a difficult prison to manage because of its size and design. They found that women had reasonable access to a wide range of primary care services but often missed appointments because of a lack of officers to escort them from their residential units. In their survey of prisoners, significantly fewer women than at comparator prisons said it was easy to see a GP. Management of long-term conditions was good and a weekly meeting on complex needs was held to ensure the challenging needs of a small number of women were managed proactively. External hospital appointments were rarely cancelled.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its 2014 annual report, the IMB reported that a shortage of healthcare staff was a concern and noted that the pressure on medical and non-medical staff was immense. The IMB noted that, despite extensive advertising, there was still no Head of Primary Healthcare at the end of 2014.

Previous deaths at HMP Holloway

16. The woman was the third Holloway prisoner to die of natural causes since 2004. There were no significant similarities with the circumstances of the other deaths.

Findings

The diagnosis of the woman's terminal illness and informing her of her condition

17. In January 2011, the woman was remanded to HMP Holloway and in August was sentenced to life imprisonment. In 2006, she had been diagnosed with breast cancer and had had a left mastectomy and lymph node clearance. She attended regular follow-up appointments at the cancer clinic at hospital.

18. The woman saw a consultant breast surgeon at hospital for annual breast check ups and appointments to discuss reconstructive surgery and the option of having her healthy right breast removed as a preventative measure. (Later tests showed that she did not have a strong genetic predisposition for breast cancer and she did not have the elective surgery.) On 4 October 2012, she had her right breast lifted and reduced and her left nipple reconstructed. In 2013, she discussed sensitivity in her left breast area with prison GP's and the breast surgeon. Investigations, including scans, did not reveal anything concerning.

19. On 1 July 2014, the woman told a prison doctor that she had back pains. The doctor noted she had a history of back pain and prescribed pain relief and advised her to rest. On 7 July, she told a nurse that she had had pain in her hip for three days. The nurse gave her some pain relief and referred her to the doctor. On 9 July, a doctor examined her and diagnosed back pain. She prescribed pain relief and recommended she have an X-ray, physiotherapy and blood tests. (She did not attend for physiotherapy or the blood tests. No reasons were recorded.)

20. On 16 July, the woman refused to attend an appointment at the hospital breast clinic. A doctor discussed this with her later and she said that she had just not felt up to it on that particular day. A further appointment was arranged.

21. On 29 July, the woman had an X-ray, of her lower spine and pelvis, which showed some degenerative changes to her spine, but no particular abnormalities. The report said her doctors should request a bone scan if there were any concerns about metastases (the spread of cancer from one organ to another). Doctors did not request a scan.

22. On 4 August, the woman told a doctor that she had been cleaning the wing and had back and shoulder pain. He diagnosed muscle strain and prescribed pain relief - nefopam and paracetemol.

23. On 12 August, the woman had her rescheduled appointment with the breast surgeon. She said she had pain in her left armpit and the surgeon arranged an ultrasound scan, which indicated nothing abnormal. She did not complain of any back or hip pain. Her next appointment was arranged for 17 February 2015.

24. On 27 August, a doctor ordered blood tests for the woman, including a liver function test. The results were normal, apart from indicating a low level of vitamin D.

25. Prison doctors saw the woman four times between September and the end of October 2014, either for medication reviews or because of pain. Doctors prescribed buprenorphine patches to help her deal with the pain from her previous surgery.

26. On 4 November, the woman told a doctor that she had pain in her back and around the mastectomy site. At her request, the doctor changed her medication from the patch to codeine, although she did not think it would deal with her pain as effectively.

27. On 11 November, a doctor examined the woman, who complained of stomach pain, nausea and weight loss. The doctor noted she had right upper quadrant pain, her abdomen was soft and there was no evidence of jaundice or liver disease. The doctor suspected she might have had gallstones and prescribed cocodamol for pain and lansoprazole to reduce stomach acid. She made a non-urgent referral to hospital for an ultrasound of her right upper quadrant and arranged blood tests. The blood tests showed that that her liver function was abnormal.

28. On 24 November, a doctor reviewed the woman and noted the blood test results. She recorded that her stomach pain seemed to be worse after eating. As she was waiting for an ultrasound scan, the doctor planned to wait until the results of the scan. On 8 December, a doctor saw her again and noted that the pain relief did not seem to be working. She planned to try codeine, but it is not clear if this was prescribed.

29. On 14 December, the woman overdosed on cocodamol and nefopam and went to hospital. (She was clear that she had not intended suicide.) The hospital discharged her the next day and a doctor saw her when she got back. She said she had continuous left sided chest pain, which was tender when the doctor examined her. The doctor noted she had not lost any weight and did not report any blood in her stools. The hospital's discharge letter referred to a fall in her haemoglobin levels but liver function test results gave no indication of any abnormality. The doctor wanted her to have blood tests anyway, but told us she did not attend for them.

30. On 22 December, the woman told a doctor that she had stomach pain and vomited occasionally. The doctor noted that she was waiting for a scan for gallstones and her weight was 8 stone 3 pounds (records show that her weight fluctuated within a few pounds, but did not fall outside normal limits for her height). She prescribed lansoprazole and planned to chase up the ultrasound scan referral. (This was chased up with the hospital on 6 January 2015.)

31. On 30 December, a doctor examined the woman, who had a pain in her shoulder and back and was unable to rotate or elevate her shoulder. The doctor concluded that the pain was muscular and prescribed ibuprofen.

32. On 12 January 2015, the woman told a doctor that she had pain in her stomach, had lost her appetite and was retching in the mornings. Her weight was 8 stone 9 pounds. The doctor noted in her medical record on examination, there was

mild abdominal distension and pain. She thought it was possible she could have gallstones. She later told us that at the time, the woman appeared reasonably comfortable and did not appear to be unwell. She adjusted her simple analgesics but did not consider she needed additional opiate medication or that her symptoms were consistent with liver metastases, of which the doctor had some experience. She arranged routine blood tests but, on 16 January, the woman did not attend the appointment for the tests or for a rearranged appointment on 26 January. We do not know the reason for this but staff said that she often decided not to attend appointments. Doctors were satisfied she had capacity to make decisions about her healthcare. The doctor asked staff to chase up the ultrasound referral again. She did this the next day and informed the doctor that it had been scheduled for 28 January.

33. On 28 January, the woman had an ultrasound and CT scan of her stomach and pelvis. On 29 January, a doctor received the report which revealed multiple lesions on her spine and liver. She was admitted to hospital that day and had a liver scan and blood tests. On 30 January, a consultant told her she had a tumour on her liver. On 6 February, after further tests, a doctor told her that no active treatment was possible and she had only three weeks to live.

34. The clinical reviewer noted that it was understandable why the woman's initial symptoms from July 2014 did not cause alarm. She had complex medical problems and had frequently sought painkillers and sedatives, for a range of reasons. A bone scan in August 2012 had been clear, an X-ray in July 2014 had been normal and in August 2014, the breast clinic had identified no concerns. The July X-ray report had noted that if doctors were concerned, a scan would be needed to identity metastatic bone disease. The clinical reviewer suggested that the X-ray and previously clear scans, her history of back pain and frequent examinations and discussions with her cancer consultant might have been sufficient to reassure the doctors at Holloway. There is no record that any of the doctors considered making a referral for a bone scan at that stage.

35. In November 2014, the woman developed abdominal pain, which was a new symptom. A blood test revealed that her liver was not functioning normally and a doctor suspected that she might have gallstones. By December, her symptoms were worse. Although the clinical reviewer understands that she did not present as generally unwell when the GPs saw her, he considered that by this point, her symptoms were suggestive of metastatic liver disease. Part of the delay was with the hospital arranging a scan, which prison healthcare staff had chased, but the clinical reviewer considered she should have been referred urgently to hospital.

36. The clinical reviewer noted that, for most of the woman's time in prison, healthcare staff managed her complex conditions well, and her care was equivalent to that she could have expected to receive in the community. However, in the final weeks of her life, the delay in diagnosing her metastatic liver disease was not equivalent care. The clinical reviewer commented that earlier diagnosis would have been unlikely to prolong her life, but would have allowed her more timely access to palliative care.

37. In the weeks before she was admitted to hospital in January, the woman saw a number of different healthcare staff. There is little evidence that GPs and other members of the healthcare team communicated with each other to review her symptoms and consider together what they might mean, in the context of her complex care. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff discuss complex cases as part of routine case management meetings, that all aspects of symptoms and treatment are considered and that they refer patients with symptoms indicative of cancer urgently to specialists, in line with National Institute for Health and Clinical Excellence (NICE) guidelines

The woman's medical treatment

38. The woman remained in hospital for palliative care after her diagnosis. Hospital care is outside the remit of this investigation.

39. Arrangements were made to move the woman to a hospice as soon as possible and a hospice admitted her on 12 February. She died there in March. Her family were with her at the time.

The woman's location

40. We are satisfied that the hospital and, particularly, the hospice were appropriate locations for the woman after her diagnosis. She moved to the hospice, where specialist palliative care was available, almost a month before she died.

Restraints, security and escorts

41. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and take account of the risk of escape, the risk to the public and factors such as the prisoner's health and mobility.

42. On 29 January, the woman was taken to hospital as an emergency and was originally restrained in hospital by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). On 6 February, when she was given a terminal diagnosis, the duty governor visited the hospital, spoke to medical staff about her condition and agreed that the escort chain should be removed. While, it is questionable whether the use of restraints was strictly necessary in the days before, we consider that a humane decision was made at the time of her terminal diagnosis and she was not restrained for the final weeks of her life.

Liaison with the woman's family

43. One of the escort officers contacted the woman's partner on 30 January to tell him that she was in hospital. Her family visited her in hospital that evening and were able to visit her a number of times before she died. They were with her at the hospice when she died in March. Records show that prison staff supported her and her family in her last weeks.

44. After the woman died an officer acted as the prison's family liaison officer. She contacted the woman's partner the next day to offer condolences and support.

45. The prison held a memorial service on 23 March. The funeral was on 31 March and the officer and another prison representative attended. The prison contributed to funeral costs in line with national guidance.

46. We are satisfied that prison staff supported the woman and her family appropriately during her final illness, and advised and supported her family after her death.

Compassionate release

47. Exceptionally, prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months and fulfil other criteria. There is no record that the woman indicated that she wanted to apply for compassionate release and prison staff did not consider her suitable.

48. The woman had been sentenced to life imprisonment for murder in August 2011, with a minimum period to service of 30 years before she could be considered for release. We therefore recognise that compassionate release would have been very unlikely. We also note that, at the time of her diagnosis, she was given only three weeks to live. It would have been difficult to make the necessary arrangements for release in this time and, as she quickly moved to a hospice, this would have had little practical effect.

Action plan

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff discuss complex cases as part of routine case management meetings, that all aspects of symptoms and treatment are considered and that they refer patients with symptoms indicative of cancer urgently to specialists, in line with National Institute for Health and Clinical Excellence (NICE) guidelines.	Accepted	There are systems in place at HMYOI Holloway to discuss complex health cases. Staff have been reminded that during routine case management meetings, where a patient's symptoms and treatment are considered prisoner's with complex health needs will be discussed. Any patient with symptoms of cancer will be referred to specialists in line with NICE guidelines. This will be evidenced through SystmOne (electronic patient records), which tracks all referrals and requests to external hospitals. There is also a forum in place at HMYOI Holloway for GPs and healthcare staff to discuss patient's wellbeing and to improve ways of working. Any action points that arise from deaths in custody are discussed within the local care quality, and integrated care quality meetings which are minuted.	Head of Healthcare 31 Aug 2015	